DHS Extract Information			
Field Name	**Description**	**Type & Length**	**Comments**
PATIENTID	Unique identifier for the member.	VARCHAR2(12)	
PATIENTDOB	The date of birth for the member.	DATE Format = CCYYMMDD	
PATIENTGENDER	Indicates the sex of the member. **Valid Values:** U - Unknown M - Male F - Female	VARCHAR2(1)	
PRODUCT		VARCHAR2(3)	Default to "FFS - Fee for Service"
LINEOFBUSINESS	Identifies the medical assistance program that is supported in the system. **Benefit Plan code values will be provided.**	VARCHAR2(5)	Benefit Plan code values will be provided.
CLAIMID	Number assigned to a claim processed in the system; used for control purposes.	VARCHAR2(17)	
CLAIMTYPE	Code that specifies the type of claim record.	VARCHAR2(1)	
CLAIMSEQNUM	The number of the detail on a claim record.	VARCHAR2(3)	
CLAIMSTATUS	Indicates the status of a claim in the system. **Claim Status Code Values:** **'P' - Paid, 'D' - Denied.**	VARCHAR2(1)	

CLAIMLINESTATUS	Indicates the status of the detail in the MMIS system. **Detail Status Code Values: 'P' - Paid, 'D' - Denied.**	VARCHAR2(1)	
FINANCIALPAYER	An optional business code value used to identify the payer. **TXIX - Title 19; WCDP - WI Chronic Disease Program; WWWP - WI Well Woman Program**	VARCHAR2(4)	Data for three financial payers will be included TXIX, WCDP and WWWP.
PAIDDATE	This date represents CHECK ISSUE date that corresponds with the first financial cycle run for Payers that finalize the claim on that cycle.	DATE Format = CCYYMMDD	
SERVICESTARTDATE	Date on which services were first performed for a recipient.	DATE Format = CCYYMMDD	
SERVICEENDDATE	Service Line Date. Used to store the service line "To Date" where relevant.	DATE Format = CCYYMMDD	
BILLEDSERVICEUNITS	The number of units billed for the service.	NUMBER(15,3)	
ALLOWEDSERVICEUNITS	The number of units allowed for the service.	NUMBER(15,3)	
DIAGNOSISCODE1	The first (Primary) diagnosis code that was keyed on the claim. This is also the discharge diagnosis code for UB92 claims.	VARCHAR2(7)	
DIAGNOSISCODE2	The second diagnosis code that was keyed on the claim.	VARCHAR2(7)	DHS uses standard national code set.
DIAGNOSISCODE3	The third diagnosis code that was keyed on the claim.	VARCHAR2(7)	
DIAGNOSISCODE4	The fourth diagnosis code that was keyed on the claim.	VARCHAR2(7)	

DIAGNOSISCODE5	The fifth diagnosis code that was keyed on the claim.	VARCHAR2(7)	
PROCEDURECODE	CPT -4 or HCPCS Code used to identify a medical, dental, or DME procedure.	VARCHAR2(6)	DHS uses standard national code set.
MODIFIERCODE	Code used to further define a procedure provided. **Modifier Code values will be provided.**	VARCHAR2(2)	Modifier Code values will be provided.
MODIFIERCODE2	Code used to further define a procedure provided. **Modifier Code values will be provided.**	VARCHAR2(2)	
REVENUECODE	System assigned key used to uniquely identify a revenue code. **Revenue Code values will be provided.**	VARCHAR2(4)	Revenue Code values will be provided.
PLACEOFSERVICE	The place of service code representing the location where the service was performed.	VARCHAR2(2)	DHS uses standard national code set.
TYPEOFBILL	The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.	VARCHAR2(3)	DHS uses standard national code set.
TOTALCHGAMT	Amount requested by provider for services rendered.	NUMBER(10,2)	
ALLOWEDAMT	Amount approved to pay for services provided to a recipient.	NUMBER(10,2)	

DEDUCTIBLEAMT	This is the amount of patient liability that was used on the claim.	NUMBER(10,2)	
COPAYAMT	Amount paid by recipient for services rendered.	NUMBER(10,2)	
OTHERINSURANCEAMT	The dollar amount paid by Medicare for the services provided.	NUMBER(10,2)	
PAIDAMT	Amount sent to a provider for payment of services rendered to a recipient.	NUMBER(10,2)	
TPLAMT	This is the total amount paid by other payers for this detail.	NUMBER(10,2)	
PROVIDERID	Provider ID value	VARCHAR2(15)	**Note:** Some denied claims may not have Billing Provider